Attachment B : School Health Services Provider Standards Self -Assessment for Contracted Entities and Site Visit Confirmation

*Date:*_____ *Name of Center/School:*_____ *District :*_____

*Self- Assessment completed by:*_____ *Date:*_____

*Site Visit Representative:*_____ *Date:*_____

Telephone number and E-mail Address:_____

A. Minimum, General School Health Services Center Requirements		**YES**	**NO**	**STATUS (Completed by DPH Staff on date of Assessment)**	**YES**	**NO**
1.	Documented proof of determination of need for a Center has been met. Examples: a. Formal needs assessment or statement of need based on school data analyzed specifically for your center and discussed with the school board or governing entity b. Data on the % of students eligible for free and reduced meals c. School board or governing entity approval for implementing a SBHC at the said site d. School board or governing entity approval for types of services needing approval (examples): • Pregnancy testing • Diagnosis and treatment of STDs • Reproductive health • HIV testing and counseling e. Memorandum(s) of Understanding f. Contract with school					

Attachment B cont.: School Health Services Provider Standards Self -Assessment for Non-Contracted Entities

A. Minimum, General School Health Services Center Requirements cont.		YES	NO	STATUS (Completed by DPH Staff on date of Assessment)	YES	NO
2.	Written policies on: a. Consent for treatment b. Program and facility operations c. HIPAA and other confidentiality practices d. Billing practices e. Policy on Registration f. Quality Assurance g. Onsite services and connecting to other services not onsite or afterhours h. Communicable disease reporting to DHSS, DPH					
3.	The Center must display signage in accordance with school protocols that includes: a. the official Center name and sponsoring agency b. the Center room number c. the Center telephone number d. hours of operation e. SBHC services offered					
4.	There must be at least one administrator responsible for the Center's overall management, quality of care and coordination with school personnel.					
5.	There must be a licensed physician that serves as the medical director of the site(s) and evidence of ongoing (at least quarterly) involvement of the medical director in clinical policy and procedures development, records review and clinical oversight.					

Attachment B cont.: School Health Services Provider Standards Self -Assessment for Non-Contracted Entities

B. Environmental School Health Services Center Requirements		**YES**	**NO**	**STATUS (Completed by DPH Staff on date of Assessment)**	**YES**	**NO**
1.	The Center has adequate space to accommodate staff, patients, laboratory and clinical activities.					
2.	The Center is in compliance with all building and safety codes.					
3.	If there is an onsite laboratory, the Center is in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations for the type of lab tests performed: a.CLIA Certificate #:_____ b.Expiration Date: _____ c. Copy provided:_____					
4.	Although there may be differences in health services per site and some rooms/areas are used for multiple purposes, the following must be present within the center: a. designated waiting/reception area b. at least one exam room c. at least one sink (hot and cold water) d. counseling room/private area e. toilet facility with a sink with hot and cold water f. office/clerical area g. secure storage area for supplies and medications h. designated lab space with sink and hot water I. secure and confidential storage areas J. phone line exclusively dedicated for the Center					

Attachment B cont.: School Health Services Provider Standards Self -Assessment for Non-Contracted Entities

C. Provider Health Services Center Information

List days of week and times of the day spent working at the Center. Be specific, (i.e. Monday 9a-4p and Thurs 1p-3:30p)

DAY	Hours	DAY	Hours
___Mon.	_____	____Fri.	_____
___Tues.	_____		
___Wed.	_____		
____Thurs.	_____		

Name of the Provider:_____ Title of the Provider:_____

List days of week and times of the day spent working at the Center. Be specific, (i.e. Monday 9a-4p and Thurs 1p-3:30p)

DAY	Hours	DAY	Hours
___Mon.	_____	____Fri.	_____
___Tues.	_____		
___Wed.	_____		
___Thurs.	_____		

Name of the Provider:_____ Title of the Provider:_____